determined as follows:

A. Computation and review guidelines. A state-operated community service, and any facility whose payment rates are governed by closure agreements, receivership agreements, or rate-
setting procedures for newly constructed or newly established facilities or approved Class A to Class B conversions under Section 12.000, is not eligible for a salary adjustment otherwise granted under this section. For purposes of the salary adjustment per diem computation and review in this section, the term "salary adjustment cost" means the facility's allowable program operating cost category, employee training expenses, and the facility's allowable salaries, payroll taxes, and fringe benefits. The term does not include these same salary-related costs for either administrative or central office employees.

For the purposes of determining the amount of salary adjustment to be granted under this section, the Department must use the reporting year ending December 31, 1996, as the base year for the salary adjustment per diem computation.

B. Salary adjustment per diem computation. For the rate period beginning July 1, 1998, each facility shall receive a salary adjustment cost per diem equal to its salary adjustment costs multiplied by 3.0 per cent, divided by the facility's resident days.

C. Submittal of plan. A facility may apply for the salary adjustment per diem calculated under this item. The application must be made to the Department and contain a plan by which the facility will distribute the salary adjustment to employees of the facility. For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative, after July 1, 1998, may constitute the plan for the salary distribution. The Department will review the plan to ensure that the salary adjustment per diem is used solely to increase the compensation of facility employees. To be eligible, a facility must submit its plan for the salary distribution by December 31, 1998. If a facility's plan for salary distribution is effective for its employees after July 1, 1998, the salary adjustment cost per diem is effective the same date as its plan.

D. Cost report. Additional costs incurred by facilities as a result of this salary adjustment are not allowable costs for purposes of the December 31, 1998, cost report.

E. Salary adjustment. In order to apply for a salary adjustment, a facility paid pursuant to the performance based contracting demonstration waiver project, must report the information referred to in item A in the application, in the manner specified by the

Department.

Section 17.030 **Emergency relocations for ICF/MR residents.** In emergency situations, the Department may order the relocation of existing ICF/MR beds, transfer residents, and establish an interim payment rate under the rate-setting methodology for up to two years, as necessary to ensure the replacement of original services for the residents. The payment rate will be based on projected cost and is subject to settle-up. An emergency situation exists when it appears to the Department that the health, safety, or welfare of residents may be in jeopardy due to imminent or actual loss of use of the physical plant or damage to the physical plant making it temporarily or permanently uninhabitable. The subsequent rate for a facility providing services for the same residents following a temporary emergency situation must be based upon the costs incurred during the interim period if the residents are permanently placed in the same facility. If the residents need to be relocated for permanent placements, the temporary emergency location must close and the procedures for establishing rates for newly constructed or newly established facilities in Section 12.000 must be followed.

Section 17.040 **Crisis capacity demonstration project.** A demonstration project for a two year period for one facility to provide crisis intervention for up to four individuals was approved by the state legislature. Additional costs for the demonstration project were based on new staff required, less the current staff to be deleted. Additional costs for meal assistants were then determined for the project. A resident day divisor was computed based on estimated occupancy of the ICF/MR and the Crisis Center using the new license capacity. The additional costs were then divided by the estimated resident days (92%) to arrive at the per diem.

Effective for services rendered from April 1, 1996, to September 30, 1996, and for rate years beginning on or after October 1, 1996, the maintenance limitation in Section 7.010, item A, subitem (2), for this facility is calculated to reflect capacity as of October 1, 1992. The maintenance limit is the per diem limitation otherwise in effect adjusted by the ratio of licensed capacity days as of October 1, 1992, divided by resident days in the reporting year ending December 31, 1993.

17.045 **Rate adjustment for medically fragile individual.** Beginning July 1, 1996, the Department shall increase reimbursement rates for a facility located in Chisholm and licensed as an ICF/MR since 1972, to cover the cost to the facility for providing 24-hour licensed practical nurse care to a medically fragile individual admitted on March 8, 1996. The Department shall include in this higher rate a temporary adjustment to reimburse the facility for costs incurred between March 8, 1996 and June 30, 1996. This higher rate will be calculated using Medicare cost-based principles of reimbursement.

Once the resident is discharged, the Department will reduce the facility's payment rate by the amount of the cost of the 24-hour licensed practical nurse care.

Section 17.050 **Downsizing demonstration projects.** A demonstration project for one facility to downsize from 45 beds to 21 beds and a second facility to downsize from 15 beds to 11 beds. The projects must be approved by the commissioner, and must include criteria for determining how individuals are selected for alternative services and the use of a request-for-proposal process in the selection of vendors for alternative services. The projects must also include alternative services for residents who will be relocated, time lines for that relocation and decertification of beds, and adjustments of each facility's operating cost rate under Section 7.000 as necessary to implement the project.

Each facility's aggregate investment-per-bed limit in effect before downsizing must be the facility's investment-per-bed-limit after downsizing. Each facility's total revenues after downsizing must not increase as a result of the downsizing project. Each facility's total revenues before downsizing will be determined by multiplying the payment rate in effect the day before the downsizing is effective by the number of resident days for the reporting year preceding the downsizing project.

For purposes of this project, the average medical assistance rate for home- and community-based services must not exceed the rate made available under Minnesota law.

Section 17.060 **Assignment of mortgage payment.** If a facility requests the Department to assign its monthly mortgage payment to the Minnesota Housing Finance Agency or other government entity, the Department shall comply provided that a mutually acceptable written agreement between the parties governing the transactions is developed and signed by the parties.

Items 10 to 13 are subject to the Health Care Financing Administration approval of an amendment to Minnesota's State plan. The Department agrees to seek approval from the Health Care Financing Administration and make its best efforts to obtain such approval. If items are not approved by the Health Care Financing Administration, the parties agree to negotiate in good faith to compensate the Provider in a like manner, subject to Health Care Financing Administration approval.

10. The administrative cost limitations in Section 7.010 shall not apply on the interim and settle-up cost report payment rates. The administrative cost limitation on the interim and settle-up cost report for administrative costs including the allocated portion of payroll taxes and fringe benefits shall be _____ per day for each day covered by the interim/settle-up period, not to exceed a total of _____. The amounts under this item will be established after 90 days of management experience by the managing agent from the effective date of this agreement and shall be incorporated into the computation of the interim payment rate which shall be retroactive to _____.

11. The central office cost allocation requirements of Section 3.040 shall not apply to the interim and settle-up cost report payment rates for the managing agent's central office costs associated with managing the Facility, except that additional directly identified costs of the managing agent must be allocated to the Facility, and shall be non-allowable costs. The manager's fee established under paragraph 4 of the Management Agreement shall be an allowable administrative cost of the Facility subject to paragraph 10 above.

12. If the payment rate that would have been established effective _____, under Attachment 4.19-D (ICF/MR), includes a payback which is the result of the application of those laws and rules, the Provider agrees to repay the Department that amount, as may be adjusted for resolved appeals, at the end of the closure period. Any other outstanding appeals shall be resolved in accordance applicable laws and rules.

13. During the period of closure, the Provider may rent portions of the physical plant to the general public for non-ICF/MR services, provided that the income earned from such rental is offset in total against the Facility's allowable property-related costs on the settle-up cost report. The operating and property cost allocation provisions of Attachment 4.19-D (ICF/MR) relating to assigning the cost of renting to non-ICF/MR services shall not apply for the portion of the closure period during which the renting of portions of the physical plant to the general public for non-ICF/MR services occurs.

METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES FOR NURSING FACILITY SERVICES PROVIDED IN STATE-OWNED FACILITIES

PURPOSE AND SCOPE:

This plan describes the methods and standards for determining payment rates for nursing facility (NF) services provided in State-owned facilities.

In general, per diem payment rates are determined annually on an interim basis with final settlement occurring after each State fiscal year.

METHODOLOGY:

Payment rates for State-owned nursing facilities are determined annually on a cost-related basis using Medicare principles of reimbursement as specified in *Provider Reimbursement Manual* - HCFA 15, parts I and II, with the following exceptions.

Interim rates are calculated on a per diem basis for each state fiscal year (July 1 to June 30) for individual State-owned nursing homes by dividing the sum of allowable anticipated costs by the projected patient days.

Anticipated costs include salaries, current expenses (fuel, utilities, food, drugs, and other expenses), repairs and betterments, depreciation of buildings and equipment, building bond interest, other capital requirements, and other expenses related to patient care, such as central office support (program supervisory staff), collections administration, other indirect costs (department personnel, medical director, information systems, and program analysis), and statewide support costs (central payroll, statewide personnel), and other State agency support to State facilities. Projected patient days are determined from population estimates, based upon actual patient days and trends shown from prior years.

The per diem limits calculated under the Medicare principles of reimbursement are evaluated under Section 1861 (v)(1) which methodology is set out in Medicare Reimbursement Manual, HCFA 15-I, Section 2828. This calculation, as provided by the Medicare intermediary, establishes the routine service cost limit.

To arrive at the interim Medicaid per diem rate, the Medicare routine service limit is modified by adding to it the projected ancillary service costs, physician service costs, property related costs, and other costs not subject to the routine service limit.

Final rates are determined by dividing the total routine service costs subject to the limitation by the patient days. The net allowable routine costs are added to the capital, ancillary, professional and other costs not subject to the limit. The sum of the allowable routine service costs and the cost not subject to the limit are divided by patient days to arrive at the actual reimbursed costs.

METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES FOR NURSING FACILITY SERVICES PROVIDED IN STATE-OWNED FACILITIES

PURPOSE AND SCOPE:

This plan describes the methods and standards for determining payment rates for nursing facility (NF) services provided in State-owned facilities.

In general, per diem payment rates are determined annually on an interim basis with final settlement occurring after each State fiscal year.

METHODOLOGY:

Payment rates for State-owned nursing facilities are determined annually on a cost-related basis using Medicare principles of reimbursement immediately prior to October 1, 1983, as specified in Health Insurance Manual -15, with the following exceptions.

Interim rates are calculated on a per diem basis for each state fiscal year (July 1 to June 30) for individual State-owned nursing homes by dividing the sum of allowable anticipated costs by the projected patient days.

Anticipated costs include salaries, current expenses (fuel, utilities, food, drugs, and other expenses), repairs and betterments, depreciation of buildings and equipment, building bond interest, other capital requirements, and other expenses related to patient care, such as central office support (program supervisory staff), collections administration (collections for regional treatment centers), other indirect costs (department personnel, medical director, information systems, and program analysis), and statewide support costs (central payroll, statewide personnel), and other State agency support to regional treatment centers. Projected patient days are determined from population estimates, based upon actual patient days and trends shown from prior years.

The per diem limits calculated under the reimbursement principles in effect prior to October 1, 1983 are evaluated under Section 1861 (v)(1) which methodology is set out in Medicare Reimbursement Bulletin, Skilled Nursing Facility #80, dated November 6, 1987. This calculation, as provided by the Medicare

intermediary, establishes the routine service cost limit.

To arrive at the interim Medicaid per diem rate, the Medicare routine service limit is modified by adding to it the projected ancillary service costs, physician service costs, property related costs, and other costs not subject to the routine service limit.

Final rates are determined by dividing the total routine service costs subject to the limitation by the patient days. The net allowable routine costs are added to the capital, ancillary, professional and other costs not subject to the limit. The sum of the allowable routine service costs and the cost not subject to the limit are divided by patient days to arrive at the actual reimbursed costs.

METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES FOR ICF/MR SERVICES PROVIDED IN STATE-OWNED FACILITIES

PURPOSE AND SCOPE:

This plan describes the methods and standards for determining payment rates for services provided in State-owned intermediate care facilities for the mentally retarded (ICFs/MR).

In general, per diem payment rates are determined annually on an interim basis with final settlement occurring after each State fiscal year.

METHODOLOGY:

Payment rates for State-owned ICFs/MR are determined annually on a cost-related basis using Medicare principles of reimbursement as specified in *Provider Reimbursement Manual* - HCFA 15, parts I and II, with the following exceptions.

Interim rates are calculated on a per diem basis for each State fiscal year (July 1 to June 30) by dividing the sum of anticipated allowable costs by the projected patient days.

Allowable costs include salaries, current expenses (fuel, utilities, food, drugs, and other expenses), repairs and betterments, depreciation of buildings and equipment, building bond interest, other capital requirements, and other expenses related to patient care, such as central office support (program supervisory staff), collections administration, other indirect costs (department personnel, medical director, information systems, and program analysis), statewide support costs (central payroll, statewide personnel), and other state agency support to State facilities. Projected patient days are determined from population estimates, based upon actual patient days and trends shown from prior years.

Final rates are determined at the end of the fiscal year by dividing total costs by in-house patient days and therapeutic visit days. For State-owned ICFs/MR, both in-house patient days

and therapeutic visit days are included as days paid under Medicaid as specified in Attachment 4.19-C. The occupancy rate required by Attachment 4.19-C does not apply to State-owned ICFs/MR.